



Natural Gifts Holistic Center, LLC

Client Intake Form

Reflexology



Please turn off or silence your cell phone

Name: _____ Date of Birth: _____

Phone Number(s): _____

Emergency Contact: _____ Telephone: _____

Reason for Treatment: _____

Are you under a Dr.'s care: _____

Dr. 's Name: _____ Phone Number: _____

Medication: _____

Vitamins/ Herbs: _____

Yes No Do you suffer from Hay Fever?

Yes No Do you suffer from Asthma?

Yes No Do you smoke?

Yes No Do you eat regular Meals?

Yes No Is your diet well balanced?

Yes No Do you suffer from food allergies? _____

Yes No Do you binge eat?

Yes No Do you Overeat?

How much of these items are in your daily diet:

Fresh Fruit _____

Tea _____

Fresh Vegetables _____

Coffee _____

Protein _____

Fruit Juice _____

Dairy Produce _____

Soft Drinks _____

Sweet Things _____

Water _____

Added Salt _____

Other _____

Sugar _____

Alcohol _____ Weekly _____

Yes No Do you see daylight in your workplace?

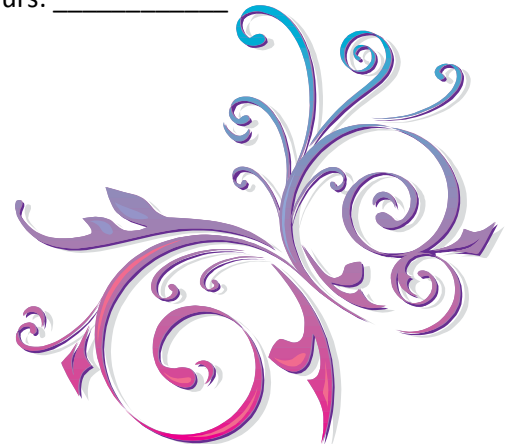
Ability to Relax: Good Poor Average

Sleep Pattern: Good Poor Average No. of Hours: _____

Do you suffer from: Nervous Tension Depression Anxiety

Have you had Recent Surgery? _____

Any surgery (medical or cosmetic including Botox)? _____





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Muscular Problems: Neck Back Rheumatism Aches and Pains Stiff Joints

Digestive Problems: Constipation Bloating Liver Gall Bladder Stomach

How many Bowel Movements do you have a day? _____

Circulation: Heart Blood Pressure Fluid Retention Tired Legs Varicose Veins
Cellulite Kidney Problems Cold Hands and Feet

Geneological: Irregular Periods PMS Menopause H.R.T.
() Yes () No Are you using birth control? Type: _____
Lat Menstrual Cycle _____

Nervous System: Sensitive Migraine Tension Headaches Stress Depression

Immune System: Prone to infection Sore Throats Colds Chest Sinuses
() Yes () No Do you take regular antibiotics? _____

Skin Type: Dry Oily Combination Sensitive Dehydrated
() Yes () No Dermatitis () Yes () No Psoriasis
() Yes () No Acne () Yes () No Allergies
() Yes () No Eczema

Please Initial:

- () I understand that Reflexology is not a cure; it has been known to assist in healing the body.
- () I understand that Reflexology can increase fertility, and Massage Therapy by Zada or its Therapists are NOT held responsible if pregnancy occurs un-planningly.
- () Massage Therapy by Zada and its Therapists are not held responsible if you chose not to seek medical advice. Massage Therapy by Zada's Therapist are not here to prescribe or diagnose.
- () To the Best of you knowledge you have answered everything honestly and correctly.

Client Signature: _____

Date: _____

